CHILDREN'S MEDICAL GROUP, LTD
6780 W. THUNDERBIRD RD., STE A101
PEORIA, ARIZONA 85381
(602) 843-1991 FAX (602) 843-3224

PARENT'S INFORMATION

Mother's Name_____ Date of Birth_____ Social Security #_____-_____-_____
Home address_____
Street City State Zip
Employer_____
Employer Phone_____ Occupation_____
Home Phone_____ Cell Phone_____ Email_____

Father's Name_____ Date of Birth_____ Social Security # _____-_____-_____
Home address_____
Street City State Zip
Employer_____
Employer Phone_____ Occupation_____
Home Phone_____ Cell Phone_____ Email_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone / Text Message Confirmation _____
☐ Home Phone Confirmation _____
☐ Work Phone Confirmation _____

I AUTHORIZE **INFORMATION ABOUT MY CHILD'S HEALTH** BE CONVEYED VIA:

☐ Cell Phone / Text Message Confirmation _____
☐ Home Phone Confirmation _____
☐ Work Phone Confirmation _____

Parent or Guardian's Signature_____ **Date**_____

STEP-PARENT / LEGAL GUARDIAN (*If Applicable*)

Name_____ Date of Birth_____ Social Security #_____-_____-_____
Home address_____
Street City State Zip
Employer_____
Employer Phone_____ Occupation_____
Home Phone_____ Cell Phone_____ Email_____

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☐ Home Phone Confirmation _____
☐ Work Phone Confirmation _____

Parent or Guardian's Signature_____ **Date**_____

INSURANCE INFORMATION

Primary Insurance Company Name	Name of Policy Holder	Policy / ID Number	Group Number
Secondary Insurance Company Name	Name of Policy Holder	Policy / ID Number	Group Number

CHILDREN'S NAME	M OR F	DATE OF BIRTH	LIVES WITH

Emergency Contact_____ Phone Number_____ Relationship_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly from my insurance company to the physicians of Children's Medical Group for Medical Treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If Children's Medical Group (CMG) is not a provider on my insurance, full payment is due on the date of service. If CMG is a provider on my insurance, then any deductible, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees and all other costs. I hereby authorize CMG to examine and treat my child when necessary. I also authorize the release of my child's protected health information, acquired in the course of examination to carry out treatment, payment and health care operations.
FINANCIAL/ OFFICE POLICY & HIPAA:
I have read and understand the foregoing financial and office policy, and agree to abide by the terms of this policy. I ALSO ACKNOWLEDGE that I have received a copy of the notice of Privacy Practices.

Responsible Party Signature _____ Date _____ / _____ / _____